CAPACITY BUILDING IN COMMUNICATIONS:

An Examination of the Polio Eradication Initiative

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for the CHANGE Project and Partners on
Communication for Polio Eradication

Contents

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Background

Since May 1988, when the World Health Assembly (the governing body of the World Health Organization, or WHO) declared its resolve to eradicate polio, much progress has been made toward that goal. Under the global Polio Eradication Initiative, several regions of the world have been declared polio-free. In other areas of the world, the spread of the disease has been severely reduced. By the year 2001, the number of polio endemic countries had been reduced to 10, and hopes are high for total eradication of the wild poliovirus by 2005. These 10 priority countries where there are still "reservoirs" of poliovirus are in Africa and South Asia. Violent conflict and resistance to immunization have made eradication a particularly difficult goal in many of those areas.

From the beginning, the four strategies or "pillars' of polio eradication have been as follows:

- Routine immunization with OPV (oral polio vaccine),
- Supplementary additional doses of OPV, delivered during National Immunization Days (NIDs)
- Mop-up campaigns
- Certification-standard surveillance for all cases of acute flaccid paralysis and wild poliovirus.

It has been widely acknowledged that communications and social mobilization efforts have made an important contribution to effectively implementing those strategies. For example, the Taylor Commission[1] report states: "Social mobilization as utilized by the EPI-Polio has relied on massively utilizing IEC, including mass media, strengthening existing community organization, and involving political and community leaders. … The three components were identified as having strong positive effects." [2] The report also cites social mobilization as "the variable with most positive effects in all countries." [3]

Communications in support of worldwide polio eradication, however, was not envisioned as a significant activity. Epidemiological strategies (i.e., the four "pillars"), not programmatic strategies, were the primary focus for the eradication effort. Therefore, provision for capacity building in communications was not made in the early planning stages. In 1996, however, WHO/AFRI hired a Communications Advisor for Africa to support polio eradication through communications and social mobilization. Subsequently, both WHO and UNICEF have created and filled several regional- and national-level communications and social mobilization positions. In addition, many of

[1] Pan American Health Organization, Special Program for Vaccines and Immunization, "The Impact of the expanded Program on Immunization and the Polio Eradication Initiative on Health Systems in the Americas: Final Report of the 'Taylor Commission'" March 1995.
[2] Final Report of the "Taylor Commission," p. 14
[3] Final Report of the "Taylor Commission," p. 17

the Interagency Coordinating Committees (ICCs), which provide coordinated inputs to national Expanded Program on Immunization (EPI) programs and to national Polio Eradication Initiative (PEI) programs, have created Social Mobilization Committees (SMCs) to coordinate national communications planning and implementation.

The need to deploy many people to influence behavior and to foster increased acceptance of immunization services, whether at health facilities, in communities or in homes, has created the need for capacity to be built in communications. Because of the determined international focus on interrupting the transmission of wild poliovirus, however, little attention has been paid to institutionalizing communications capacity nor to evaluating these efforts.

This consultant was asked to review capacity-building efforts in communications related to polio eradication for the period covering 1996 – 2002 by gathering and examining studies and reports and by interviewing key personnel who have been involved in those efforts. As a result of the review, the consultant was to prepare a "draft 15-30 page analytical paper on lessons learned regarding the best strategies for capacity building, including recommendations to the polio/immunization partners." The consultant conducted interviews (by telephone or in person) with individuals from the World Health Organization (in Geneva, as well as in country offices), UNICEF, USAID, the CHANGE Project, the Voice of America and the BASICS II Project. In addition, the consultant reviewed the written and audio-visual materials that are listed in the Bibliography at the end of this paper. The consultant summarized her findings in the present document, and also presented her findings at a June 14, 2002 meeting in New York City titled "Capacity building in communications related to polio eradication" (summarized at the end of this paper).

Findings

Anecdotal evidence gathered during the research as well as during the discussions held in the meeting at which the research was presented suggests the following lessons from the capacity-building in communications activities that have been carried out in relation to the Polio Eradication Initiative:

1. Program planners should include planning for communications activities from the beginning of an initiative. Key decision-makers should be brought "on board" very early regarding the importance of integrating the planning for communications support into overall program plans from the start.

2. Clear goals and strategies for communications activities should be identified at the onset and periodically reviewed for their relevance, applicability and practicality.

3. Key communication indicators should be identified and used to monitor progress from the beginning of activities.

4. Decisions regarding all aspects of communications planning should be based upon data gathered as part of regular monitoring activities. Local capacity for data analysis and use may have to be enhanced to ensure this.

5. Once communications goals and strategies, as well as key indicators, have been identified, criteria for selection of communications personnel should be defined and used to select appropriate staff.

6. Communications experts should be very familiar with the basic medical/scientific terminology related to the technical area in which they are working (e.g., polio eradication). This enhances their credibility with the technical content experts, who might otherwise overlook the valuable contributions that the communications experts have to offer.

7. Tools as well as procedures should be in the simplest form possible to make them accessible to and usable by the largest number of staff possible. It is important to allow for some flexibility for local adaptation of tools and procedures, where possible.

8. Intersectoral collaboration, enhanced by the addition of partners who may not have been involved before (e.g., Voice of America), can strengthen efforts to move the program forward effectively. In PEI, various organizations, such as WHO, UNICEF, USAID, and others have worked together to ensure better program achievement. The Voice of America (VOA) has also contributed to this goal.

9. Program planners and implementers should work closely enough with donors to ensure clear communications and continued financial support.

The Need for Further Research and Study

Although these findings are based on the opinions of some of the key persons involved, to identify “lessons learned” from activities designed to build capacity with greater assurance, it would be useful to examine more systematically both the **effort** that has been expended as well as the **effectiveness** of the activities. Measuring **level of effort** is fairly straightforward and is usually easily done. One may count, for example, the number of workshops that have been held, the number of technical assistance days spent in the field, or the number of reference materials that have been produced. It is a measure of the INPUTS or resources that have been committed to the endeavor.

Measuring the **level of effectiveness** of capacity-building activities is a much more complicated endeavor. Ideally, measurement of effectiveness compares baseline data against information gathered about the post-intervention situation. The absence of baseline measure makes drawing conclusions from a post-intervention assessment more difficult.

Measuring the effectiveness of an intervention is also facilitated by the use of comparison groups. Analysis of data gathered about two comparable groups, when one of the groups has received an intervention and the other has not, may allow certain conclusions to be drawn regarding the effectiveness of the intervention. When no equivalent comparison groups are available for study, it is difficult to draw conclusions about the effect that an activity or group of activities has had.

Finally, to measure the effectiveness of an intervention, it is necessary to document and consider the effect of the concurrent implementation of other activities that may influence the intended outcomes. If, for example, an activity is carried out to improve the interpersonal skills of health care providers, a follow-up evaluation of the learners' skills should include identification and examination of other events or activities that may have influenced how providers and patients interact. Such events or activities might include the re-stocking of needed supplies, which had been unavailable for some time, or the addition of new staff, which frees up providers to spend more time with patients. If factors such as these are not taken into account, conclusions reached about the effectiveness of the intervention may be erroneous.

From the beginning of the Polio Eradication Initiative, the one all-consuming focus was the interruption of the transmission of the poliovirus. Therefore, little if any strategic thinking was done about how to evaluate the efforts to build national, regional and local capacity in communications and social mobilization. The absence of baseline data, and the lack of comparison groups and of a clear accounting of the concurrent implementation of other activities make it challenging to evaluate the effectiveness of the activities that have been carried out.

The need for evaluation data has been recognized and highlighted in a number of reports about capacity building in communications within the polio eradication effort. For example, during the 2001 Mid-Year Meeting of the Advisory Group of Polio Partners, Dr. K. Suresh stated that "quantitative and qualitative studies are needed when monitoring communication interventions,"[4] and in the report, "Communication for Immunization and Polio Eradication in Mozambique," the authors state the need for "collecting and using reliable quantitative and qualitative information as the basis for solid communication planning and implementation." [5] In addition, Mogedal and Stenson, in their publication "Disease Eradication," explain that "In contrast to the financing input, there are no regular systems for tracking the manpower input and disaggregating it for different programme activities." [6]

Although efforts have been made to examine what has been done in capacity building for communications, a formal evaluation has not yet been conducted. For instance, five case studies were carried out in sub-Saharan African countries to do the following: "a) document communication activities for polio eradication, routine immunization and

[4] Suresh, K. *Monitoring Communication Interventions: Indicators and Methodologies* in "Reaching the Unreached Child," p. 21.
[5] "Communication for Immunization and Polio Eradication in Mozambique," p. 6.
[6] Mogedal, S. and Bo Stenson, "Disease Eradication: friend or foe to the health system?" p. 24.

surveillance; b) exchange effective and innovative experiences; and c) provide recommendations for the improvement of communication interventions." [7] The study teams reviewed documents, carried out interviews and prepared recommendations based on a comparison of processes followed in each country with generally accepted best practices in communication. Real evaluation, however, was limited to those few communication evaluations that had already been undertaken in countries. The studies could draw no firm conclusions regarding the effectiveness of the communications interventions in helping increase utilization of immunization services (and therefore in reducing transmission of the poliovirus). The recommendations specific to capacity building that were put forward by the study teams – i.e., "Strengthen health education," "Dedicate resources to conducting quality research" (the results of which can be used to strengthen communications activities) and "Develop more strategic communication interventions" – should be considered as possible areas of inquiry if more formal examination of PEI capacity building efforts are planned.

As program stakeholders move toward allocating additional funds and other resources toward Polio Eradication, they need information about the relative effectiveness of the different interventions that have been tried. The following is the description of a framework that may be used to organize the retrospective evaluation of efforts to date, as well as the prospective evaluation of future endeavors.

Communication/Social Mobilization

Communication and social mobilization activities to build and maintain enthusiasm and support for immunizing large numbers of children with anti-polio vaccine may be grouped into two overall categories: on the one hand, mobilizing enthusiasm and support and raising consciousness among political elites, bureaucracy and civil society; and on the other, mobilizing communities to increase acceptance of immunization services. Advocacy for support of polio eradication efforts has therefore taken place in many settings. Political figures and other influential leaders have been enlisted to help draw attention to and build support for PE. Television and radio, as well as highly publicized sporting events have been used to raise awareness and to stimulate action. One example was the "Polio Eradication Challenge Cup" that was held in Nigeria in 1998. In addition, regional and national meetings about the Polio Eradication Initiative have provided opportunities for informal contacts such as "hallway chats" and other kinds of interpersonal contacts among government officials, private sector representatives, donors and other stakeholders.

Communication and social mobilization designed to increase utilization of immunization services also makes use of mass media as well as interpersonal approaches. In the Polio Eradication Initiative, for example, messages have been transmitted via radio and television, the use of bullhorns or through "miking," and through the use of print materials. In addition, t-shirts, hats and other clothing or items for personal use have

[7] "Communication for Routine Immunization and Polio Eradication: A synopsis of five sub-Saharan country case studies," p. 4.

been distributed as incentives to help engage the help of health facility staff as well as community volunteers.

Interpersonal communication has been used extensively to stimulate and support community and individual utilization and acceptance of immunization services. Many service providers have received training in improved interpersonal communication skills, and numerous community volunteers have been mobilized and trained to educate caregivers about the value of immunization and to encourage them to get their children vaccinated. In many countries, traditional leaders and healers have agreed to join in the effort to promote vaccinating the youngest members of society against polio.

Capacity Building

Capacity building may be defined as helping others to acquire new skills or to build upon or improve existing skills. It implies an exchange between two or more parties – generally, one with the necessary knowledge, skills and experience to help the other make improvements. Although it may be a one-way transfer of knowledge and/or skills, ideally it represents an exchange during which both/all parties gain some advantage. It can take many forms and involve many levels of complexity.

Those who operate in the world of development often engage in capacity building. They assess, document, train – with the best of intentions, and hopefully, with a desire to "do good." The gains that are made as a result of those efforts, however, are not always readily apparent. One can count the number of people trained, the number of brochures distributed – even the number of people trained by those who have been trained. But it is not always clear just what constitutes "success" in capacity-building. It is not enough to count trainees, number of workshops carried out, number of "tools" written and pre-tested. How can we go beyond the "counting" to look at the outcomes of capacity-building efforts and perhaps even at the results that are attained?

Other aspects of capacity building must also be explored. The mechanisms that are used to build capacity should be carefully examined to ensure the most appropriate use of scarce resources and limited time. The relative merits of different approaches must be considered before a method of capacity building is selected. If, for example, training is identified as the appropriate mechanism for building or strengthening skills, how and where should that training be carried out? When, on the other hand, other mechanisms for building capacity are deemed appropriate, such as short- or long-term technical assistance, mentoring, networking, and development and dissemination of support materials, their selection and use must be carefully considered in the context of whom the beneficiaries will be. Other questions must also be answered, such as "Where do they live/work?" "Who can best reach them and serve their needs?" "What are their needs?"

In the past several years, much time, money and effort have been dedicated to various efforts to build capacity in communications in support of polio eradication – and recently, routine EPI activities, as well.

The paper frames an examination of these efforts in the following way: it looks at capacity building as a system. It identifies the inputs, the processes and the outputs of the system and begins to draw some conclusions about what has been accomplished. With additional information gathered during the 2002 meeting, "Capacity-Building for Communication on Immunization and Disease Control" (June 14, 2002), we can also begin to outline an approach for examining the effectiveness of what has been carried out.

For the purposes of this exercise, the "inputs" or methods of capacity building will be grouped into the following categories: training, mentoring, networking/distance consultation and support, development and dissemination of support materials, and institutional strengthening. A short definition of each kind of "input" will be followed by a brief summary of how the method has been used to build capacity in communications for polio eradication. Very little formal evaluation of these capacity-building efforts has been carried out; however, this paper will include some of the questions that should be asked in the context of evaluating those efforts.

Methods of Capacity Building

Technical Assistance

Technical assistance may be of short or long duration and may take many forms. however, for the purposes of this paper, it will be considered to be the provision of assistance by one person or group of people to another person or group to support the latter's achievement of specific objectives. Technical assistance may occur via training, mentoring, development and dissemination of materials. In the context of this paper, technical assistance does not refer to the provision of direct financial or logistical support.

Training

For the purposes of this paper, training is considered to consist of well-organized opportunities for participants to acquire the necessary understanding and skills to carry out one or more specific tasks. It generally involves one or more individuals transferring clearly defined products – generally, knowledge and skills – to another person or group of people; however, the process by which this transfer occurs may take a variety of forms. For example, training may occur in classrooms or laboratories, in on-the-job settings, via self-instructional materials, or via radio or other communication technology.

Cascade strategy

One of the most common training strategies used to build capacity relies upon a "cascade" effect of skills and knowledge transfer. According to this strategy, a central group of individuals receive training in a particular technical content area, as well as in at least some aspects of adult education and training. This central group is then expected to train others in the same technical content, and even perhaps in techniques of training. The cascade strategy may be perceived as a way to build the capacity of

many individuals in a relatively short amount of time. In reality, however, to be successful, training carried out via a cascade strategy requires certain elements for success. These are as follows:

- *Authority*
- *Resources*
- *Capacity*
- *Responsibility*
- *Non-threatening*
- *Support and encouragement*[8]

- **Authority:** Those who have been trained as trainers must have explicit authority to organize and train others. Without such authority, it will be difficult if not impossible for them to garner the necessary cooperation and resources to identify, convene, train and follow up with those whom they have been asked to train in the "cascade" strategy.

- **Resources:** For cascade training to occur, those who have been trained to organize and carry it out must be supplied with the necessary resources to do so. Although seemingly obvious, this important point may in fact be overlooked as plans are made for large-scale implementation of a training initiative.

- **Capacity:** Although it is generally acknowledged that the use of participatory training techniques *is desirable*, what is often overlooked or ignored is that "Participatory methods are difficult to master, particularly when trainers themselves have been educated didactically."[9] The time and resources needed to prepare trainers to effectively incorporate participatory methods, such as role-plays and demonstrations, into their training "repertoire" are likely to make the cascade training strategy lengthy and costly.

- **Responsibility:** Those who have been trained will need to perceive the training of others as part of their job responsibilities. Even when a position lacks an explicit job description that outlines the tasks that should be performed, the implicit understanding of expectations usually will guide performance. If training others has not been incorporated in either the explicit or implicit job expectations, the "cascade" training may not be carried out in an effective way.

- **Non-threatening:** Information and skills are often perceived as "privileged commodities." Therefore, it may be difficult for those who have been trained as trainers to share them with others who are likely to be subordinate to them.

[8] Bryce, J et al ."Rethinking PHC Training" Atlanta, GA: International Health Program Office, Centers for Disease Control and Prevention, p. 5.
[9] Bryce, J et al ."Rethinking PHC Training" Atlanta, GA: International Health Program Office, Centers for Disease Control and Prevention, p. 5.

Support and encouragement: Before embarking upon implementation of the "cascade" strategy, as well as while activities are being carried out, those who have been trained as trainers should perceive that they have support and encouragement to proceed from their supervisors as well as from their colleagues.

If these elements are not present, it may be difficult for a cascade strategy of training to be carried out well and therefore for skills and information to be conveyed efficiently and effectively to many levels of workers. In that case, perhaps program planners may have to examine the use of other strategies to build capacity in program participants.

Centralized Training Team

Another training strategy involves the use of one or more teams of "master trainers" who travel to various locations to deliver standardized and (hopefully) high-quality training. This strategy offers the advantage of providing participants with a more standardized "package" of skills-building activities, but it has the disadvantage of taking a longer time to implement. In every situation, stakeholders and planners need to examine the advantages and disadvantages of these strategies, as well as of others, which might involve partial reliance upon distance learning or use of new technologies, before designing their training program.

Evaluation of Training

As noted above, to draw conclusions about the success of a training activity, it is necessary to examine both the effort that has been expended as well as the effectiveness of the activity. Measuring the level of effort **for training is fairly straightforward and is usually carried out easily. One may count, for example, the number of workshops that have been held, the number of people who have been trained, or the number of hours that have been spent in training. However, measuring effort becomes more challenging in the case of communications for polio eradication because of the use of the cascade strategy for training. Centralized documentation of the regional and national training workshops that have been carried out is relatively easy to access; but a systematic effort to document all of the subsequent training workshops that have been held at state, provincial and local levels will need to be organized to collect information from those levels (see table).**
Unfortunately, little, if any, training follow-up has been done at the country level.[10]

The following table summarizes available information on communication training that has taken place related to PEI:

[10] Mary Harvey, personal communication, 5/24/02.

TRAINING ACTIVITIES UNDER PEI

Activity	Participants / Trainers	dates
INTERNATIONAL		
Initial workshop to identify needs (Agreed on framework which resulted in the Communication Handbook)	WHO, UNICEF, BASICS, MOH / Silvia Luciani, Grace Kagondu, Yaya Drabo	April 1988
Communication workshop during or attached to Kathmandu cross-border meeting	UNICEF, WHO, CDC, governments	March 2000??
Media workshop on immunization safety: Integrated into wider immunization safety: 2 workshops	In collaboration with GTN	2000 & 2001
EPI managers meetings: Every block organizes a meeting yearly. These sessions always include a session on communication (1 hour on AV)	EPI Managers Communication focal points sometimes participate	Yearly
MLM training: 1 day on communication training for EPI managers. 3 regional and 2 country-level trainings	EPI managers	2000-2002
REGIONAL		
Regional trainings using the Communications Handbook	West Africa, Central Africa, East Africa, Southern Africa – Dakar, Douala, Nairobi, Widhoek / Silvia Luciani, Lora Shimp, Grace Kagondu, Yaya Drabo, Narcisse de Madeiros, consultants	1998 – 1999 (Repeated for Western, Eastern & Southern countries in 2002)
Review/Follow up workshops and specific workshops on NIDs, synchronized NIDs	Western and Central Africa MOH communication focal points / WHO, UNICEF, BASICS regional staff	From 1999 onward
Regional TOT (to create a resource team for strategic communication planning and to provide follow up support to countries) (held in Dakar)	Lora Shimp, Grace Kagondu, Narcisse de Madeiros, Yaya Drabo	1999
NATIONAL		
National workshops on communication planning (Zambia, Burkina Faso, Ghana, Nigeria, Cameroon, RCA, Gabon, Congo, DRC, Zimbabwe, Ethiopia, Tchad, Equatorial Guinea, Liberia)	Social mobilization committee members and provincial focal points	From 1999 to date (Possibly yearly to plan NIDs)
Workshops on communication training and planning	Sudan	Apr – June 2000
Communication training and planning workshop	Afghan country team in Pakistan	Apr 2000

PROVINCIAL		
Provincial training & planning workshops Plus NIDs planning workshops Nigeria, Zambia	Focal persons from districts	From 1999 onward (Possibly every year for NIDs in most countries)

As noted above, measuring the **effectiveness** of training in capacity building for communications in support of polio eradication is challenging because of the lack of baseline data, comparison groups and documentation and analysis of the concurrent implementation of other activities. However, the following framework might be used in the future.

Framework for Evaluating Training

The first question that should be asked about each training activity is whether the participants acquired the skills that the training was designed to address. For example, as a result of participating in a course or workshop on strategic planning for communications, were the participants better able to prepare strategic plans after the workshop than before? Was each participant able to do so by the end of the training, or were only some? What level of mastery was expected of the participants, and what level did each one reach? These questions should be answered at the conclusion of the training activity.

The second question relates to changes in the participants' job performance as a result of training. What were they able to do after training that they could not do before? For example, are they preparing strategic plans or leading the preparation of strategic plans for the first time? If they have prepared strategic plans before, but the quality of those plans was not optimal, are the strategic plans they prepare after training of better quality than those prepared before the training? These are the kinds of questions that should be answered at an appropriate interval after training.

The final level of inquiry involves what impact the training has had upon the expected outcome of the program within which it is carried out, although it is usually quite difficult to isolate the effect of training from the effect of other factors. In the case of polio eradication, how effective was the training in contributing to increasing coverage? If the other questions have not been answered, then this one cannot be answered.

Mentoring

The mentoring relationship is an on-going one, during which the mentor helps the learner develop new skills over time as the two work together toward a common goal or set of goals. Mentoring generally involves a one-to-one relationship between an individual who shares his or her greater knowledge and experience in a particular field of expertise with another individual to enhance the latter's capacity to carry out a job or task.

To look at the **level of effort** of the mentoring that has taken place within the communications component of the Polio Eradication Initiative, one may count the number of short- and long-term advisors that have been deployed, where they have been assigned and how long each assignment has lasted (see table).
The following table summarizes available information on communication mentoring that has taken place related to PEI:

MENTORING ACTIVITIES UNDER PEI

Activity	Participants	dates
During monitoring trips by regional and sub-regional staff (e.g., working with	Members of the committee or national staff in many countries / WHO, UNICEF, BASICS, other?	Ongoing
Through consultants: consultants work with the members of the committee and national staff (e.g., over a 3 month period)	WHO, UNICEF, BASICS, other?	Ongoing
Long-term consultants 1year in priority countries: DRC, Angola, Tchad, Niger, Nigeria, Ethiopia	UNICEF, WHO	Since 2000
Support visits from regional and sub-regional staff: many countries. Mostly to review plans	WHO, UNICEF, BASICS, other	Ongoing
WHO promotes use of Field Guide	Thilly de Bodt Jonathan Veitch	2002
BASICS provided **technical assistance** to ICC national and sub-national staff	BASICS	2000(?)

However, to assess **level of effectiveness**, one would need to have some measure of pre- and post-performance of the worker/organization that receive the mentoring assistance. For example, if the mentoring relationship was established to improve the design and development of communications materials, can an improvement in materials be observed? Can materials produced before the mentoring be compared to those produced afterwards? Is there good reason to believe that the mentoring influenced or brought about change, or could other factors have contributed to any changes that might be observed? Does the improvement continue to be observable after the mentoring has ended? And if there is any change in immunization coverage, can we attribute it to the mentoring that has taken place?

Networking
Networking is defined here as intensive and continually evolving communication among people engaged in related areas of work. It connects participants to a professional network and provides them with opportunities to seek out and become acquainted with new people in the service of work-related goals.

The **level of effort** of individuals and organizations in communications activities related to PEI may be measured in terms of the formation of on-going committees and groups that have emerged to support the Initiative, as well as participation in those groups. For example, the Advisory Group for Communications for Polio Eradication/EPI has a growing number of members and has met twice a year since 1997 -- once near the end of year in Harare and once at the mid-year point in June in New York City. Recently-formed GAVI sub-regional working groups deal with communications (among other concerns), and there are social mobilization committees in most of the countries where PEI activities take place. An evaluation of the contribution of networking to polio eradication efforts would have to take into account how many groups were formed, how many members were active participants, and how often they met.

To measure the **effectiveness** of their contributions to communications in polio eradication, however, one would have to examine what contribution their existence and the participation of their members has made to communications for polio eradication. For example, have planning or implementation skills been improved? Can any change in coverage be ascribed to participation in such bodies? How can changes be ascribed to the existence of the networking between individuals and groups and not to the effect of other interventions or influences?

The following table summarizes available information on communication networking that has taken place related to PEI:

NETWORKING ACTIVITIES UNDER PEI

Activity	Participants	dates
First meeting of the Advisory Group convened by AFRO in Brazzaville	WHO, UNICEF, BASICs, Rotary, USAID	Feb 1997
End year meetings of the Advisory group	As above plus VOA	1997 – to date
Joint meeting of Advisory Group and GAVI ATF	Same as above	2001
Initiation of **mid-year annual meeting** for communications for polio eradication	The Polio Partners	1998
Sub-regional meetings of focal points	Mainly MOH, sometimes other EPI partners	Since 1999
2 Sub-regional working groups after GAVI: East and Southern Africa and West and Central Africa	WHO, UNICEF, CVP, Red Cross, BASICS	Regular meetings since 2001
E mail exchange: A lot of exchanges of all types – i.e., consultation, sharing, comments on plans and ideas happens -- with colleagues in other agencies and with field staff		
Joint missions to countries: Nigeria, Angola	WHO, UNICEF	2002

With other programmes: consulted for technical input by other DDC programmes. Working on project to integrate communication activities of DDC programmes (IMCI, MAL, etc)	Who?	Ongoing?
Sharing of materials and tools: share materials from other countries regularly. Synchronized NIDs has resulted in sharing common messages and materials.	Who?	Ongoing?
Meetings of **the Polio/EPI Communication/Social Mobilization Advisory Group**	WHO, CEC, UNICEF, GAVI/PATH, VOA, BBC Trust, Boston Globe, USAID, the CHANGE Project, the BASICS Project … plus communications officers and managers from regional and national offices	Twice yearly since 1997 (mid-year and end-of-year)
Sub-regional PE meetings	WHO	??
Kathmandu Cross-border meeting	UNICEF, WHO, CDC, governments	March 2000
Calcutta TCG/SEARO meeting and communication workshop	Technical communication staff	August 2000

Distance Consultation and Support

Distance consultation and support involves the provision of technical assistance by one individual or group to another from a distance. Generally, the assistance offered takes the form of the transfer of knowledge, provision of feedback and advice, and assistance in accessing information that might otherwise be difficult to obtain.

The **level of effort** of the distance consultation and support offered to improve communications for polio eradication could be measured by counting the number of phone calls made, as well as the number of emails sent. In addition, one could review pertinent listservs for evidence of effort expended.

The **level of effectiveness** of the distance consultation and support, however, would need to be measured in terms of the recipients' increased capacity to perform their duties – as a result of the consultation/support. For example, one could measure whether there was an increase in capacity to plan or to implement programs. Were programs therefore planned or implemented more effectively? And one might examine how improved planning and implementation increased coverage.

Development and Dissemination of Support Materials

To measure the **level of effort** of the development and dissemination of support materials, one can count the number of manuals, training guides, booklets, newsletters, CD-ROMs, etc. that are produced and distributed. The table below presents a preliminary listing of materials that have been produced as part of the communications for polio eradication. To measure level of effort, it would be necessary to complete this

list, as well as to identify how well the materials were distributed. For example, was dissemination carried out in such a way that the materials reached the people and groups that could best use them? For example, were the materials in the appropriate language and was the format – paper, electronic, read-only or editable – the most useful for the recipients?

The **level of effectiveness** of those materials could be examined in light of two key aspects: quality of material produced and effect of the material. In the first instance, each of the materials might be evaluated according to criteria such as accuracy of technical information, organization and presentation of information, and identification of the appropriate audience for the material. In addition, however, the material should be evaluated in terms of how well it has served to assist its intended beneficiaries. One example of a key document produced as part of the Polio Eradication Initiative is the *Communication Handbook for Polio Eradication and Routine EPI*. Another is the *Checklists and Easy Reference Guides on Communication for Polio Eradication*. Both of these publications, along with others produced as part of the Polio Eradication Initiative, might be examined in terms of how well they were developed, as well as what impact their availability and use have had upon those who lead the way in efforts to eradicate poliovirus.

The following table summarizes available information on materials development activities that has taken place related to PEI:

MATERIALS-DEVELOPMENT ACTIVITIES UNDER PEI

Activity	Participants	dates
GUIDES		
Field Guide for Communication in Polio Eradication, Routine EPI and AFP Surveillance	WHO	1997
Polio Eradication Initiative: Monitoring Service Delivery During National Immunization Days, Assessing the Local Capacity to Strengthen Disease Surveillance	BASICS	1998
Advocacy: A Practical Guide with Polio as a Case Study"	WHO	1999
"Communication Handbook for Polio Eradication and Routine EPI (plus Facilitator's Guide)	UNICEF, WHO, AFRO, BASICS, CHANGE, MOH POLIO/EPI Focal Persons, Polio Partners	2000
"Mid-Level Management Course for EPI Managers: Communication for Immunisation Programmes" (Draft 2)	WHO/AFRO	May 2002

"Hints for Social Mobilization and Communication Support for Polio Eradication"	USAID	??
Polio Eradication Reporter's Handbook	Thad Penas, Voice of America (VOA)	??
TOOLS		
Communication for Polio Eradication and Routine Immunization: Checklists and Easy Reference Guides	USAID/BASICS II and CHANGE projects with input from all partners (WHO, UNICEF)	2000 2002 published by WHO
"Communication Monitoring Indicators"	Polio Partners	2001 (?)
"Monitoring Form for Communication in Polio Eradication, Routine EPI and AFP Surveillance"	Polio Partners	2001 (being revised, 2002)
"Community Surveillance Kit"	CHANGE Project, USAID	2001
REPORTS/STUDIES		
The Impact of the Expanded Program on Immunization and the Polio Eradication Initiative on Health Systems in the Americas: Final Report of the "Taylor Commission	Pan American Health Organization	1995
"Report of the Second Meeting on the Global Commission for the Certification of Polio Eradication"	WHO	1997
Field studies on the PEI in Tanzania, Nepal and Lao PDR	WHO, UNICEF, USAID (CHANGE)	1998 - 2001
"Communication for Immunization and Polio Eradication in Mali: A Joint Case Study by UNICEF, WHO/AFRO, USAID"	UNICEF, WHO/AFRO, USAID	1999
"Communication for Immunization and Polio Eradication in Mozambique: A Joint Case Study by UNICEF, WHO/AFRO, USAID"	UNICEF, WHO/AFRO, USAID	1999
"Communication for Immunization and Polio Eradication in Nigeria: A Joint Case Study by NPI, WHO, USAID/BASICS, USAID/JHU-PCS"	NPI, WHO, USAID/BASICS, USAID/JHU-PCS	1999
"Communication for Immunization and Polio Eradication in the Democratic Republic of the Congo: A Joint Case Study by BASICS, WHO, and UNICEF"	BASICS, WHO, UNICEF	1999
Global Health: Factors Contributing to Low Vaccination Rates in Developing Countries	General Accounting Office of the U.S. Government (GAO)	1999
"Immunization Promotion Activities: Are They Effective in Encouraging Mothers to Immunize Their Children?" *Social Science and Medicine* (49)	Ricardo Pérez-Cuevas, et al. p. 921-932.	1999
Polio Eradication CD 1 & CD 2	WHO	1999, 2000

"Communication for Routine Immunization and Polio Eradication: A Synopsis of Five Sub-Saharan Country Case Studies" (Individual studies disseminated via partners' website and communication initiative)	UNICEF WHO USAID-funded BASICS USAID-funded CHANGE	2000
"Disease Eradication: Friend or Foe to the Health System?" Synthesis Report from Field Studies on the Polio Eradication Initiative in Tanzania, Nepal, and the Lao People's Democratic Republic	Sigrun Mogedal and Bo Stenson, WHO/Geneva	2000
"Mid-Year Consultative Meeting of Polio Partners on Communication for Polio Eradication"	UNICEF HQ (NY)	July 2000
"Polio Plan of Action 2000 – 2005"	WHO & UNICEF	June 2000
"Eleventh Africa Scout Conference in Libreville, Gabon: Mission Report"	UNICEF Angola, Scouts Association	3-12, Sep 2001
"Evaluation of Polio Communications in Pakistan"	WHO, UNICEF, USAID/CHANGE	2001
"Health Interventions and Health Equity: The Example of Measles Vaccination in Bangladesh," *Population and Development Review* (27; 2)	Michael A. Koenig, David Bishai, and Mehrab Ali Khan; pp. 283-302	2001
"Reaching the Unreached Child: Mid-Year Meeting of the Advisory Group of Polio Partners on Communication for Polio Eradication"	UNICEF HQ (NY)	June 2001
"Special Meeting of SEAR Technical Consultative Group on Poliomyelitis Eradication" (CD-ROM 1)	WHO	2001
"Capacity Building in Communications for Polio Eradication" (PowerPoint Presentation)	EPI-MOHFW Bangladesh	2002
"Impact of Targeted Programs on Health Systems: A Case Study of the Polio Eradication Initiative," *American Journal of Public Health* (vol. 92, no 1)	Benjamin Loevinsohn, et al.	2002
Polio Review in Nigeria	Polio Partners	2002
"Progress Toward Global Eradication of Poliomyelitis, 2001"	Centers for Disease Control and Prevention (CDC), MMWR / Vol. 51 / No. 12	March 29, 2002
Role of Social Mobilization in SNIDS-1	Noble Thalari, UNICEF Social Mobilization Team	6 May 2002
TECHNICAL GUIDELINES AND UPDATES		
"Polio Vaccines, What You Need to Know"	CDC	1999
"Poliomyelitis, OPV and Misconceptions on Vaccinations	U. S. Pharmacopeia	2000
Standardized Terms of Reference for Consultants and Consultant Report Outline	UNICEF	2001

LISTS		
"Annotated List of Documents, Tools and Materials on Communication for Polio Eradication and EPI"	UNICEF	2001
Polio Partners Contact List	UNICEF	??
NEWSLETTER/E-MAIL MAGAZINE		
"Drum Beat" e-mail magazine	Communication Initiative	? - present
Polio News (a quarterly WHO/EPI newsletter)	WHO, Rotary International, UNICEF, CDC, USAID	1998 – present? [found were Nov 2001 (13) and Feb 2002 (14)]
MEETING SUMMARIES		
"Mid-Year Meeting of the Advisory Group on Polio Partners for Communication on Polio Eradication" **(**CD-ROM)	WHO, CEC, UNICEF, GAVI/PATH, VOA, BBC Trust, Boston Globe, USAID, the CHANGE Project, the BASICS Project … plus communications officers and managers from regional and national offices	2001
"Meeting on the Impact of Targeted Programmes on Health Systems: A Case Study of the Polio Eradication Initiative"	WHO/Geneva	Meeting date: 16-17 Dec 1999. Printed: Sept 2000
"Communication Planning: Regional Trainings on Routine EPI/NIDS in Ghana"	Dr. Mercy Essel-Ahun, Ghana EPI Manager; Ms. Lora Shimp, BASICS/HQ Tech Officer	16-26 Aug 2000
NEWS/MEDIA COVERAGE		
News reports, feature stories, public service announcements, radio dramas and TV programs	VOA	1997 - 2002
"Polio – the Beginning of the End"	VOA	1998
"Reporters on Reporting the Last Days of Polio" (orientation video)	VOA	1998
VOA Sport Polio PSA cassettes and CD-ROM	VOA & World Net Television	
VOA Radio Soap Operas	VOA & World Net Television	
Polio web pages for program communication and social mobilization (UNICEF GPP web pages	UNICEF	May 2000
Radio and TV spots for polio campaign in India (Uttar Pradesh and Bihar)*	2 media consultants from BBC	Oct 99 – March 2000

INTER-ACTIVE MEDIA		
Polio Quiz – to be used in schools, youth journals, and by NGOs	UNICEF Gender, Partnerships and Participation Section & Voices of Youth	2000
"Internet Chat" (An FGD on youth participation in Polio Eradication Initiative, conducted in an on-line chat	UNICEF	2000
OTHER		
Country materials and tools exchange (e.g., monitoring checklists, IEC, guides, etc.)	Partners	Continuous
Country level materials development -- All countries	MOH and EPI partners	Continuous
Photo Gallery (website)	Rotary International	

Institutional Strengthening

For the purposes of this paper, institutional strengthening refers to the strategic addition of personnel, equipment or supplies to an organization to enhance its performance. To measure the **level of effort**, one might do an inventory of the positions, supplies and equipment that have been dedicated to the PEI. Examples of the positions added are included in Annex 1 of this report. It is beyond the scope of this report to inventory the equipment and supplies that have been apportioned to the Initiative.

A measure of the **level of effectiveness** of the institutional strengthening might focus attention upon the strategic role of each category of staff added. For example, how have the contributions of the regional staff differed from those of national or district staff? How has national performance, for instance, been changed by the addition of new staff, equipment or supplies? And what effect have these attempts to strengthen institutions had at other levels? Finally, can examples like these of institutional strengthening be shown to have contributed to increased coverage?

The following table summarizes available information on institution-strengthening activities that have taken place related to PEI:

INSTITUTIONAL-STRENGTHENING ACTIVITIES UNDER PEI

Activity	Participants	dates
Grace Kagondu hired at AFRO	WHO	1996
SEARO gets 2 communications positions		??
WCARO gets 2 positions		??
UNICEF organized girl and boy scouts in Angola to promote polio immunizations	UNICEF	2001
VOA hired a Coordinator for Polio activities and other health programming	VOA	1997

Performance Improvement

It has been well documented that merely improving the capacity of an individual or a group of people to carry out a particular task or cluster of tasks is not in and of itself necessarily sufficient to guarantee successful implementation of that task. Many factors influence performance, including:

- the availability of resources (time, financing, personnel, etc.);
- the nature of the environment in which performance will take place (supportive or not); the quality (or presence) of supervision and guidance; and
- the presence or absence of incentives (monetary or otherwise), among others.

Although this paper will not explore these other factors, it acknowledges that the success of capacity-building efforts must be measured with those factors in mind. It is often difficult to evaluate the impact of training, for example, by measuring the performance of the recipients of training when they are back on the job. Despite being able to demonstrate competence in a particular task or constellation of tasks at the end of training, participants may have difficulty maintaining their mastery of new skills when they re-enter their work environment. Other factors, such as the inappropriate selection of participants for training, the re-assignment of newly trained personnel to positions where their new skills have no bearing, and the often-conflicting demands of poorly defined job responsibilities, can minimize or eliminate the effect of enhancing capacity.

Evaluation – Retrospective and Prospective

A retrospective evaluation of the activities for capacity building in communications that have been carried out as part of the Polio Eradication Initiative could yield important information for policy-makers as they plan for future activities. Anecdotal evidence (for example, "…it seems that interpersonal communication, particularly through town criers, community leaders and women's organizations, was very effective in mobilizing rural and semi-rural populations." [11]) may be used to guide the development of a well-organized and purposeful qualitative evaluation of efforts that have been carried out but not evaluated. Level of effort may be quantified in many instances, but to move toward an evaluation of the level of effectiveness of each of these methods of capacity building, in-depth, semi-structured interviews might also be used as important tools for gathering information and helping gauge the contribution of each. It is hoped that this paper will provide the basis upon which such an evaluation may be built.

[11] Communication for Routine Immunization and Polio eradication: A synopsis of five sub-Saharan country case studies," p. 10.

Recommendations

- Each major partner organization should designate a liaison for capacity building.
- Major partners should share, via meetings and email, their own agencies' activities related to capacity building for PEI and immunization in general.
- These liaisons and other interested persons should meet in conjunction with annual communications meetings to discuss activities and lessons learned.
- Partners should encourage governments to include explicit capacity-building objectives and activities in their plans.
- Partners should develop and circulate guidelines for evaluating training, including how to analyze evaluation data, and use them to improve future training activities.
- Partners should strengthen/expand their incipient database of consultants for communications for PEI and routine immunization.
- National programs should base communications planning and materials development on research and program monitoring.
- Communications planning and materials development and production should be coordinated centrally, but with local flexibility for adaptation and use.
- National support for local adaptation and/or development of materials should be given in a timely fashion.
- Partners should develop and circulate guidelines for how to improve monitoring of communications activities and decision-making on the basis of monitoring results.

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Meeting Summary: Capacity Building for Communication on Immunization and Disease Control

Rockefeller Foundation, New York City, June 14, 2002

In collaboration with UNICEF, WHO, and other polio partners, USAID/CHANGE organized and facilitated a meeting on Friday, June 14, 2002, on lessons learned from polio eradication on how to build capacity for communication and behavior change to support immunization and broader public health initiatives. The meeting was held at the Rockefeller Foundation in New York City. Drawing on experience from UNICEF, WHO, USAID, and other partners, participants discussed what has been done so far to build capacity; what lessons we have learned; and what we should do in the future?

After an introduction from facilitator Dana Faulkner, the meeting began with a presentation by Gail Naimoli, examining what has been done so far to build capacity in communications during the Polio Eradication Initiative.

One of the first issues that participants brought up during the discussion of the presentation was how to further refine the definition of capacity building, and how it relates to other strategies such as social mobilization or advocacy. It was noted that persons and organizations interested in promoting capacity building would have to start by advocating for it, since it is too easy for people to focus on the immediate results for which they are held accountable and not on a long-term vision and objectives. It is important to define capacity building and also to determine what the objectives should be and how they fit with the national and regional goals, and with specific goals for immunization and disease control.

Participants were then asked to give feedback on what they believe were the lessons learned from PEI. Among the many lessons identified were the importance of: getting those responsible for making decisions on board early in planning for communication; bringing new partners into the process; simplifying models and tools and better disseminating them; securing financial support and working more closely with donors; defining clear goals and strategies from the beginning; and identifying the right human resources.

Following its consideration of lessons learned, the group discussed what the logical next steps should be. Possibilities included: producing an attention-grabbing report on the meeting and disseminating it to donors; developing a strategy for capacity building for communications; comparing alternative strategies for capacity-building ; expanding the definition of capacity building among donors; advocating for capacity building at highest levels of decision-making; raising the visibility/ priority of capacity-building needs and problems; continuing to define competencies for communication; and advocating for funding.

During the last phase of the meeting, three stations were established where participants were asked to write down ideas on what they believe the next steps should be to build capacity for: 1) routine immunization, 2) other initiatives and global efforts, and 3) within the current structure for the PEI transition period. The findings for this phase yielded wide-ranging and interesting results (see attached annex).

For routine immunization, the major area identified as an important next step is to support more collaboration and to foster partnerships. This includes encouraging south-to-south opportunities for learning; identifying and supporting national/regional institutions to provide training/capacity

building; and focusing on building capacity at the district level. Also identified as important were defining the required competencies for communications staff; ensuring recruitment of communication staff with those competencies are; developing indicators for capacity building; defining 'capacity building' and making goals specific to the country or region; simplifying existing tools and promoting adaptations locally; and lastly, working with GAVI structures to build lessons from BCI and capacity building into new efforts.

For other initiatives and global efforts, the top priority was again to build cooperation and link with other partners, particularly to identify and support national/regional institutions to provide training/capacity building; to strengthen south-to-south cooperation in communication training; and to identify institutions capable of doing capacity-building in developing countries. Other participant priorities were: identifying the right skills and recruiting for the right communication personnel; documenting and disseminating information and lessons learned; establishing a media task force for health reporting; taking advantage of new technologies for capacity building; and shifting from workshops to competency-based skills development.

Within the current structure and PEI transition period, many of the same issues were identified as priorities. The top priority was documentation and dissemination, including establishing a library of documentation and designating a committee or focal person to collect and disseminate assessments of capacity-building efforts under PEI. Other issues included developing strategies and making sure a communication infrastructure is in place; establishing communication focal points; and establishing evaluation mechanisms for all capacity-building activities.

The six-hour meeting did not permit time for the group to formally reach consensus on major conclusions and recommendations. However, there appeared to be general agreement on the following points:

- PEI communications has not been well documented. It would be worthwhile to document inputs and outputs for the benefit of future efforts, even though data for a formal evaluation are not available.

- There is a need to institutionalize, i.e. to be ready to build upon PEI communications work in preparation for the post-polio transition.

- A number of priority suggestions from the marketplace of ideas have the potential for improving the effectiveness of PEI communications work and should be vigorously pursued.

Annex A: Lessons Learned (as proposed by meeting participants)

Be proactive
- define
- identify

1. At national level, get those responsible for decision-making "on board" for communication – use data
2. Innovation – bring new partners into process (mass media – VOA – cost effective). Multi-sectoral partners
3. Simplify models for country team use (streamline)
4. Need for more professionalism in communications
5. Get communication planning on board early ; bring communications people into planning
6. Difficult to build capacity in a global campaign if building capacity is not one of the goals or strategies
7. Global tools should/could be better used/better disseminated; there is a great need for tools
   - explore their usefulness at all levels
8. Have clear goals
9. You need financial support!
10. Selection of staff is very important (e.g., communication focal points)
11. Need to work effectively with integration of tasks, responsibilities
12. Need for better understanding of capacity-building among donors; bring agency capabilities along
13. Need to invest in people within institutions
14. Look for the right mix of methods in capacity-building
15. Micro-planning = where the action is
16. Communication and capacity building must be included in all phases of planning, implementation and evaluation
17. Focus upon building health workers' skills (e.g., collect, analyze, use data)
18. Bring communication to the people – avoid diffusion along the way
19. Make an operational strategy from the beginning
20. Sit with committee and work through "issues" from the beginning
21. Health system is under-performing, despite PEI

Annex B: Possible Next Steps

1. Produce (attention-grabbing) road show of meeting and disseminate to donors
2. Develop strategy for capacity building for communication for WHO/MOHs
3. UNICEF communication capacity-building strategy to be written, to include individual lessons learned/case studies, etc.
4. Identify other (private sector) communication capacity-building strategies and compare
5. Expand definition of capacity building among donors
6. Present capacity-building issues at highest levels of decision-making; forum
7. Reflect on policy implications of capacity building vs. short-term results
8. Raise priority/visibility of capacity-building needs, problems
9. Continue work to define competencies, framework
10. Bridge the gap between capacity building in communications in polio and longer-term goals
11. Demonstrate link between capacity building in communication (objectives) to other areas
12. Support OR mechanisms for capacity building in communications innovations and research (including donors)
13. Go to scale on capacity building in communications and learn how to do it!

14. Link to GAVI and other groups working on capacity building (how to do it?)
15. Build "pull" mechanisms to training institutions for communicators (demand side). Foster/use local training/universities.
16. Fund communication capacity in local institutions/languages
17. Advocate for funding for capacity building in communications – other donors.

Annex C: Discussion/Idea Marketplace

What should we do now……..

FOR ROUTINE IMMUNIZATION

Collaboration/partnerships	**24**
• *Encourage south-to-south learning opportunities*	*9*
• *Identify and support national/regional institutions to provide training/capacity building*	*5*
• Ensure capacity-building for EPI communication in IMCI and medical school curricula	3
• Include more partners e.g. media houses, research institutions, to broaden capacity	2
• Develop stronger technology based info.-sharing	2
• Partnerships at community level with training	2
• Bring in new partners on the ground to be part of the effort	1
• Ensure intersectoral collaboration in all phases (planning, implementation, evaluation)	0
• This group and others must share face to face	0
• Build stronger link in capacity building between GAVI advocacy task force and country coordinator	0
Technical assistance/guidance	**21**
• *Urgently build district capacity*	*5*
• WHO/GAVI should require that all country EPI plans include a section of capacity building for communications that includes multiple types of activities	4
• Build capacities of program staff – not only communication staff	3
• WHO/UNICEF should recommend that every EPI and community find appropriate ways	3
• Give countries technical guidance on improving supervision and on-job capacity building	2
• Increase (national and district level) communication officers' ability to coordinate local partners, including community members, in planning and implementation	2
• Educate decision makers in MOH (national and district levels) about the different issues EPI poses to the health system	1
• Include communication modules in curriculum at medical, nursing, midwifery, etc. schools	1
• Prepare and widely disseminate case studies on how to make program staff more client-oriented	0
Recruit/fund/train communication staff	**20**
• *Ensure recruitment of communication staff with appropriate competencies*	*9*
• *Define "small, do-able" communication competencies for health staff and focus on these*	*7*
• Train all health staff to be communicators (district)	3

- Lobby for/fund communication positions with in governments 1
- Find the way to identify and strengthen the communication focal points 0

Develop indicators, measure for effectiveness 14

- *Develop indicators to measure "outcomes"* *7*
- Identify indicators for capacity-building into joint monitoring form – start monitoring and giving feedback 4
- Apply "field guide" for EPI programming, M&E effectiveness, and modify training 2
- Put in baseline measures of existing capacity in order to develop benchmarks and measure achievements 1

Improve planning/implementation, design strategies 12

- Improve capacity for collecting and using the data in designing communication interventions 4
- Establish operational strategies, at all levels 2
- Strengthen district officers' ability to document district communication activities; "data collection" at a small scale 2
- Establish reward systems for good IPC performance of health workers (in PEI) at district/service delivery points 2
- Build on microplanning and identification of high-risk areas for planning and management 1
- Think backwards: apply insights from polio eradication, more management or communication/ more in-country institutional strengthening, simplify tools… 1

Define capacity building 11

- *Define capacity building – know what your goal is – make specific goals by country region level* *7*
- Define capacity-building objectives for routine EPI and relate them clearly to standard EPI goals 4
- Define capacity building as an end in itself, not a means to an end 0

Ensure funding 9

- Create the 80% club = more investment 4
- Don't drop the ball 3
- Fund people – job cannot be done without warm bodies 2

Develop/identify/simplify tools 8

- *Simplify existing tools and promote adaptations locally* *6*
- Explore new ways/approaches in marketing EPI and immunizations 2
- Identify models that work 0

Examine past CB efforts and lessons learned 7

- *Work with GAVI structures at all levels to build lessons from BCI and capacity building into new efforts to revive routine* *6*
- Analyze capacity-building shortfalls from UCI (don't make the same mistakes) 1

Work with media 3

- Form a media task force with members of the media to develop media inclusive

programming 3

- Engage major media organizations in the development and implementation of EPI/GAVI program 0

Other **2**

- Ensure problem-based training linking research with learning 2

FOR OTHER INITIATIVES AND GLOBAL EFFORTS:

Link with other partners **34**

- *Identify and support national/regional institutions to provide training/capacity building 10*
- *Strengthen south-south cooperation in communication training 5*
- *Identify institutions in developing countries 5*
- Strengthen national and regional academic training in communication and make it more hands-on and practical 4
- Establish community of practice of stakeholders for capacity building 3
- Develop indicators in association with various partners (donors, MOH, MOE, etc.) 2
- Create ownership of communication initiatives and training within national universities 2
- Identify local institutions to assist and define role 2
- Develop programs with government, university and NGOs 1
- Try to obtain global consensus on capacity building with/in health sector reform 0
- Focus on programs that focus on institutions, not just individuals 0
- Plan capacity-building discussions with C-IMCI 0

Recruit for human resources; Identify skills **27**

- *Give health education units guidelines and TA on how to advocate for getting more human and other resources 7*
- *Lobby for communication personnel in all health programs 5*
- Ensure recruitment of the "right" people – right competencies 4
- Build capacities of program staff- not only communication staff 4
- Communication staff in all agencies/programs – advocate 3
- Recommend more health education positions at national and provincial levels and provide matching funds for new positions 2
- Lobby for/fund communication positions within governments 1
- Refine communicator competencies 1
- Identify skills for communication officers at national and district level (as training goals, indicators for capacity-building) 0
- Human resources are critical – warm bodies with right competencies 0

Disseminate/share information and lessons learned **21**

- *Gather, analyze, and disseminate worst practices – horror stories from polio - and share with Roll Back Malaria/ Stop TB 7*
- Develop simple and effective training packages on communication 4
- Streamline the communication model 3
- Change local capacity in preparing good case studies on what difference communication made in PEI/RH 2
- Incorporate "reporting out" on communication indicators at key meetings 2

- Use small scale, district-level comparison studies to measure impact of IPC activities (build skills to do this) 1
- Actively share lessons learned (re: capacity building and PEI) with GFATM, GAIN, RBM, other big initiatives 1
- Prepare a paper "what is different" among polio – TB – malaria Vaccine/population/behaviors/messages 1
- Review capacity-building initiatives across programs and regions in terms of what works/what doesn't 0
- Identify "successful" cases and understand reasons for capacity building in long term 0

Engage media **6**

- *Establish media task force for health reporting with members of the media* *5*
- Link with BBC, CNN. Involve in meetings to increase understanding of issues, to get more and better coverage of PEI and EPI 1

Develop strategies **5**

- Identify priority areas where capacity building is needed (regional, locally) 3
- Develop clear communication strategies, operational guide, indicators 2
- Gather data/info. to drive capacity-building strategies 0
- Include formulative supervision as an essential part of capacity-building 0
- Give recommendations to MOHs on capacity-building strategy for health staff 0

Advocacy **4**

- Get communications recognized as an essential partner in health interventions 4
- Clearly articulate to "directors" of health initiatives how capacity-building in communication will help them meet their states goals, to trigger programming and funding 0
- Provide simple guidelines to MOHs on how to analyze barriers to and support (more effective) counseling 0

Other **11**

- *Take advantage of new technologies for capacity-building* *6*
- *Shift from workshops to competency-based, skills development* *5*
- Resolve/ integrate the tension between "getting the job done" and capacity building 0

3. WITHIN THE CURRENT STRUCTURE AND PEI TRANSITION PERIOD:

Document and disseminate **23**

- *Intensify efforts to document (and make accessible the impact and evidence on capacity-building)* *5*
- *Establish and maintain a central "library" of polio eradication documentation* *5*
- *Designate a committee or focal person to collect and disseminate assessments of capacity-building efforts under PEI* *5*
- Collect data to improve performance, modify training 4
- Document some of the integrated work in countries 2
- Polio partners should plan and implement ideas for better dissemination of existing global tools 1
- Document what worked and did NOT work. P.E. strategies/plans/campaigns 1

Develop strategies and infrastructure **19**

- *Develop budget for communication infrastructure (internal/external)* *8*
- *Set up reward system for excellence in capacity-building* *5*
- Rapid assessments with MOHs and health staff to determine capacity-building needs for routine EPI 3
- Provocative discussion on capacity-building problems faced by polio to feed into measles 1
- Finish definition of core competencies of communication officers 1
- Train in development of simple workplans – beyond strategy 1
- Define communication micro-planning 0

Establish communication focal points **15**

- *Do an inventory of communication focal points in country, list vacant/required position (HR map)* *7*
- Make certain that current UNICEF-WHO/USAID communications positions are maintained even after no more circulation of wild polio virus 3
- Clone Grace! Leadership! 3
- Assure "core" focal points, understand the technical aspects of polio for all elements of transition to routine immunization focus 2

Evaluate **14**

- *Set up evaluation mechanisms for all capacity-building activities* *7*
- Establish benchmarks 3
- Develop/finalize indicators (effort and effectiveness) - all levels 3
- Evaluate PEI capacity-building in communications activities to date 0
- Carry out internet-based survey of existing training to assess quality 1

Technical assistance **14**

- Provide technical assistance with data collection and analysis 3
- Field technical teams to work with countries – "Stop Teams" 3
- Orient EPI and surveillance staff on capacity-building approaches 3
- Build skills to focus communication activities on remaining pockets 2
- Ensure countries with polio virus transmission receive technical support to strengthen their communication team capacity 2
- Strengthen communication ICC/working groups at national, regional level (others if needed) 1

Ensure funding **3**

- Improve capacity for local fundraising 2
- Approach donors for specific support for communications: staff, training, M&E, etc. 1
- Ensure that funding for capacity building does not stop 0

Other **3**

- Get out of tall buildings and into the field 2
- Cut funding 1
- Ellyn should keep being provocative

Persons who attended the meeting:

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